NC DIVISION MH/DD/SAS RESIDENTIAL TREATMENT MEDICAID AUDIT
FY 2009/2010

PROVIDER NAME:	**AUDIT DATE:**
PROVIDER #:	**NAME:**
CONTROL #:	**MEDICAID #:**
DOB/AGE:	**SERVICE TYPE:**
RECORD #:	**SERVICE DATE:**

RATING CODES: O = Not Met/No 4 = Met/Yes 2 =Partially Met 6 = No service note 7 = Provider name not available 8 = Repaid before audit list sent 9 = NA	**RATING**
AUTHORIZATIONS/PERSON CENTERED PLANS: Use rating of "4" or "0" for Q1 - 4	
1. Was an authorization in place covering this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**	
2. Is there a valid service order for the service billed? **a. If NOT MET list dates FROM:_____ TO: _____**	
3. Is the PCP current with the date of service? **a. If NOT MET list dates FROM:_____ TO: _____**	
4. Was the psychiatric assessment completed by an independent practitioner? **a. If NOT MET list dates FROM:_____ TO:_____**	
SERVICE DOCUMENTATION (Use Likert Scale See Guidelines): Use rating of "4", "2" or "0" for Q 5 - 10 or "6", "8", or "9", as applicable. Use "4" or "0" for Q11	
5. Is the PCP individualized per person?	
6. Does the service note(s) relate to goals listed in the PCP?	
7. Does the documentation reflect intervention/treatment for the duration of service?	
8. Does the service note reflect assessment of progress toward goals?	
9. Is the documentation signed by the person who delivered the service within the designated time frame?	
10. Are the service notes/logs individualized per person?	
11. Was face-to-face clinical consultation by a Licensed Professional provided at least 4 hrs/wk? (*Level III)* **a. If NOT MET list dates FROM:_____ TO:_____**	

QUALIFICATIONS / SUPERVISION / RECORD CHECKS: (List names of staff below) Use rating "4" or "0" for Q13-15		
12. Is there documentation that the staff is qualified (demonstrates knowledge, skills and abilities) for the service provided? **a. If NOT MET list dates FROM:_____ TO:_____**		
13. a. Is an individualized supervision plan in place for paraprofessional and/or AP staff? **b. Is the plan implemented?** **c. If "a or b" is NOT MET list dates FROM:_____ TO:_____**	**a.** **b.**	
14. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service, prior to employment? *[hired prior to 3/24/05]* **b. Was the appropriate Criminal Record check requested/completed prior to this date of service? *[hired on or after 3/24/05]*** **c. If "a or b" is NOT MET list dates FROM:_____ TO:_____**	**a.** **b.**	
15. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? **a. If NOT MET list dates FROM:_____ TO:_____**		

COMMENTS:

AUDITOR:	**LME:**